SECOND REGULAR SESSION

HOUSE BILL NO. 2086

97TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES MITTEN (Sponsor), KIRKTON, GARDNER, MEREDITH, ELLINGER, MORGAN, SCHUPP, BUTLER, KELLY (45), WEBBER, CURTIS AND MIMS (Co-sponsors).

5136L.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 195.015, 208.152, 208.153, 208.166, and 208.991, RSMo, and to enact in lieu thereof twenty-three new sections relating to health care, with a penalty provision.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 195.015, 208.152, 208.153, 208.166, and 208.991, RSMo, are repealed and twenty-three new sections enacted in lieu thereof, to be known as sections 195.015, 195.450, 195.453, 195.456, 195.459, 195.462, 195.465, 195.468, 195.474, 195.477, 208.152, 208.153, 208.166, 208.427, 208.428, 208.429, 208.430, 208.965, 208.967, 208.991, 208.998, 1, and 2, to read as follows:

195.015. 1. The department of health and senior services shall administer sections 195.005 to **[**195.425**]** **195.477** and may add substances to the schedules after public notice and hearing. In making a determination regarding a substance, the department of health and senior services shall consider the following:

(1) The actual or relative potential for abuse;

(2) The scientific evidence of its pharmacological effect, if known;

(3) The state of current scientific knowledge regarding the substance;

(4) The history and current pattern of abuse;

(5) The scope, duration, and significance of abuse;

(6) The risk to the public health;

(7) The potential of the substance to produce psychic or physiological dependence liability; and

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

(8) Whether the substance is an immediate precursor of a substance already controlled under sections 195.005 to 195.425.

2. After considering the factors enumerated in subsection 1 of this section the department of health and senior services shall make findings with respect thereto and issue a rule controlling the substance if it finds the substance has a potential for abuse.

3. If the department of health and senior services designates a substance as an immediate precursor, substances which are precursors of the controlled precursor shall not be subject to control solely because they are precursors of the controlled precursor.

4. If any substance is designated, rescheduled, or deleted as a controlled substance under federal law and notice thereof is given to the department of health and senior services, the department of health and senior services shall similarly control the substance under sections 195.005 to 195.425 after the expiration of thirty days from publication in the federal register of a final order designating a substance as a controlled substance or rescheduling or deleting a substance, unless within that thirty-day period, the department of health and senior services objects to inclusion, rescheduling, or deletion. In that case, the department of health and senior services shall publish the reasons for objection and afford all interested parties an opportunity to be heard. At the conclusion of the hearing, the department of health and senior services shall publish its decision, which shall be final unless altered by statute. Upon publication of objection to inclusion, rescheduling or deletion under sections 195.005 to 195.425 by the department of health and senior services, control under sections 195.005 to 195.425 is stayed as to the substance in question until the department of health and senior services publishes its decision.

5. The department of health and senior services shall exclude any nonnarcotic substance from a schedule if such substance may, under the federal Food, Drug, and Cosmetic Act and the law of this state, be lawfully sold over the counter without a prescription.

6. The department of health and senior services shall prepare a list of all drugs falling within the purview of controlled substances. Upon preparation, a copy of the list shall be filed in the office of the secretary of state.

195.450. 1. Sections 195.450 to 195.477 shall be known and may be cited as the "Prescription Drug Monitoring Program Act".

2. As used in sections 195.450 to 195.477, the following terms mean:

(1) "Controlled substance", the same meaning given such term in section 195.010;

(2) "Department", the department of health and senior services;

(3) "Dispenser", a person who delivers a schedule II, III, or IV controlled substance to the ultimate user, but does not include:

(a) A hospital, as defined in section 197.020, that distributes such substances for the purpose of inpatient care or dispenses prescriptions for controlled substances at the time of discharge at such facility;

(b) A practitioner or other authorized person who administers such a substance; or

(c) A wholesale distributor of a schedule II, III, or IV controlled substance;

(4) "Patient", a person who is the ultimate user of a drug for whom a prescription is issued or for whom a drug is dispensed, except that patient shall not include a hospice patient enrolled in a Medicare-certified hospice program who has controlled substances dispensed to him or her by such hospice program;

(5) "Schedule II, III, or IV controlled substance", a controlled substance that is listed in schedules II, III, or IV of the schedules provided under this chapter or the Federal Controlled Substances Act, 21 U.S.C. Section 812.

3. Notwithstanding any other law to the contrary, the provisions of this section shall not apply to persons licensed under chapter 340.

195.453. 1. The department of health and senior services shall establish and maintain a program for the monitoring of prescribing and dispensing of all schedule II, III, and IV controlled substances by all professionals licensed to prescribe or dispense such substances in this state. The department may apply for any available grants and shall accept any gifts, grants, or donations to develop and maintain the program. All funding for prescription drug monitoring program shall be provided exclusively by gifts, grants, and donations.

2. Each dispenser shall submit to the department by electronic means information regarding each dispensation of a drug included in subsection 1 of this section. The information submitted for each shall include, but not be limited to:

(1) The pharmacy federal Drug Enforcement Administration ("DEA") number;

(2) The date of the dispensation;

(3) If there is a prescription:

(a) The prescription number;

(b) Whether the prescription is new or a refill;

(c) The prescriber DEA or National Provider Identifier ("NPI") number;

(d) The date the prescription is issued by the prescriber;

(e) The source of payment for the prescription;

(4) The National Drug Code ("NDC") for the drug dispensed;

(5) The number of days' supply of the drug;

(6) The quantity dispensed;

(7) The patient identification number, including, but not limited to, any one of the following:

(a) The patient's driver's license number;

(b) The patient's government-issued identification number; or

(c) The patient's insurance cardholder identification number;

(8) The patient's name, address, and date of birth.

3. Each dispenser shall submit the information in accordance with transmission standards established by the American Society for Automation in Pharmacy, or any successor organization, and shall report data within every seven days.

4. (1) The department may issue a waiver to a dispenser that is unable to submit dispensation information by electronic means. Such waiver may permit the dispenser to submit dispensation information by paper form or other means, provided all information required in subsection 2 of this section is submitted in such alternative format.

(2) The department may grant an extension to dispensers who are temporarily unable to electronically submit the dispensation information required in subsection 2 of this section in accordance with the time frame established in subsection 3 of this section due to unforseen circumstances. In cases where an extension is granted, dispensers shall be responsible for reporting the required data in a subsequent file.

5. The department shall reimburse each dispenser for the fees and other direct costs of transmitting the information required by this section.

195.456. 1. Dispensation information submitted to the department shall be confidential and not subject to public disclosure under chapter 610 except as provided in subsections 3 to 5 of this section.

2. The department shall maintain procedures to ensure that the privacy and confidentiality of patients and personnel information collected, recorded, transmitted, and maintained is not disclosed to persons except as provided in subsections 3 to 5 of this section.

3. The department shall review the dispensation information and, if there is reasonable cause to believe a violation of law or breach of professional standards may have occurred, the department shall notify the appropriate law enforcement or professional licensing, certification, or regulatory agency or entity, and provide dispensation information required for an investigation.

4. The department may provide data in the controlled substances dispensation monitoring program to the following persons:

(1) Persons, both in-state and out-of-state, authorized to prescribe or dispense controlled substances for the purpose of providing medical or pharmaceutical care for their patients;

(2) An individual who requests his or her own dispensation monitoring information in accordance with state law;

(3) The state board of pharmacy;

(4) Any state board charged with regulating a professional that has the authority to prescribe or dispense controlled substances that requests data related to a specific professional under the authority of that board;

(5) Local, state, and federal law enforcement or prosecutorial officials, both in-state and out-of-state engaged in the administration, investigation, or enforcement of the laws governing licit drugs based on a specific case and under a subpoena or court order;

(6) The family support division within the department of social services regarding Medicaid program recipients;

(7) A judge or other judicial authority under a subpoena or court order; and

(8) Personnel of the department of health and senior services for the administration and enforcement of sections 195.450 to 195.477.

5. The department may provide data to public or private entities for statistical, research, or educational purposes after removing information that could be used to identify individual patients, prescribers, dispensers, or persons who received dispensations from dispensers.

6. Nothing in sections 195.450 to 195.477 shall be construed to require a pharmacist or prescriber to obtain information about a patient from the database. A pharmacist or prescriber shall not be held liable for damages to any person in any civil action for injury, death, or loss to person or property on the basis that the pharmacist or prescriber did or did not seek or obtain information from the database.

195.459. The department is authorized to contract with any other agency of this state or any other state with a private vendor, or any state government that currently runs a prescription monitoring program. Any contractor shall comply with the provisions regarding confidentiality of prescription information in section 195.456.

195.462. The department shall promulgate rules setting forth the procedures and methods of implementing sections 195.450 to 195.474. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to

chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

195.465. 1. A dispenser who knowingly fails to submit dispensation monitoring information to the department as required in sections 195.450 to 195.477 or knowingly submits the incorrect dispensation information shall be subject to an administrative penalty in the amount of one thousand dollars for each violation. The penalty shall be assessed through an order issued by the director of the department. Any person subject to an administrative penalty may appeal to the administrative hearing commission under the provisions of chapter 621.

2. A person authorized to have dispensation monitoring information under sections 195.450 to 195.477 who knowingly discloses such information in violation of sections 195.450 to 195.477 or who uses such information in a manner and for a purpose in violation of sections 195.450 to 195.477 is guilty of a class A misdemeanor.

195.468. 1. The department shall create and implement the following education courses:

(1) An orientation course during the implementation phase of the dispensation monitoring program established in section 195.453;

(2) A course for persons who are authorized to access the dispensation monitoring information but who did not participate in the orientation course;

(3) A course for persons who are authorized to access the dispensation monitoring information but who have violated laws or breached occupational standards involving dispensing, prescribing, and use of substances monitored by the dispensation monitoring program established in section 195.453.

When appropriate, the department shall develop the content of the education courses described in subdivisions (1) to (3) of this subsection.

2. The department shall, when appropriate:

(1) Work with associations for impaired professionals to ensure intervention, treatment, and ongoing monitoring and followup; and

(2) Encourage individual patients who are identified and who have become addicted to substances monitored by the dispensation monitoring program established in section 195.453 to receive addiction treatment.

195.474. Under section 23.253 of the Missouri sunset act:

(1) The provisions of the new program authorized under sections 195.450 to 195.474 shall automatically sunset six years after the effective date of sections 195.450 to 195.474 unless reauthorized by an act of the general assembly; and

(2) If such program is reauthorized, the program authorized under sections 195.450 to 195.474 shall automatically sunset six years after the effective date of the reauthorization of sections 195.450 to 195.474; and

(3) Sections 195.450 to 195.474 shall terminate on September first of the calendar year immediately following the calendar year in which the program authorized under sections 195.450 to 195.474 is sunset.

195.477. 1. By no later than January 1, 2016, the bureau of narcotics and dangerous drugs within the department of health and senior services shall establish a two-year statewide pilot project for the reporting of fraudulently obtained prescription controlled substances. The pilot project shall include the following:

(1) Provide a toll-free number for reporting to the bureau by physicians, pharmacists, and other health care professionals with prescriptive authority who have reason to believe that a person is fraudulently attempting to obtain a prescription for a controlled substance or is attempting to obtain an excessive amount of a controlled substance by prescription;

(2) Establish a system within the bureau for receiving such reports under subdivision (1) of this subsection along with any evidence offered or submitted by the reporter which indicates the fraud; and

(3) Forward such reports, along with any evidence offered or submitted to the appropriate prosecuting attorney or the state attorney general for investigation and prosecution.

2. On or before February 1, 2016, and February 1, 2017, the bureau of narcotics and dangerous drugs shall submit a report to the general assembly detailing the following specifics regarding the pilot project:

(1) The number of reports received under this section;

(2) The type of evidence offered or submitted indicating the fraud;

(3) The number of referrals to the attorney general and each local prosecuting attorney;

(4) The number of cases investigated and prosecuted as a result of such reporting, and the number of convictions or pleas resulting from such investigations and prosecutions. The attorney general and local prosecuting attorneys shall cooperate with the bureau in the submission and collection of the information necessary for inclusion in the report; and

(5) Any recommendations regarding continuance of and improvements in the pilot project.

Nothing in this section shall be construed as authorizing the inclusion or release of any identifying information of any reporter or person who is identified as a person who is attempting to fraudulently obtain prescription controlled substances.

3. Any person who in good faith reports to the bureau under this section shall be immune from any civil or criminal liability as the result of such good faith reporting.

4. The department of health and senior services may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

5. The department shall implement and provide all monitoring under the pilot project with existing department employees. Nothing in this section shall be construed as authorizing the hiring of additional employees to implement this pilot project and the department is required to implement this pilot project upon receipt of gifts, grants, and donations received for such purpose, without any additional state appropriations or department staff; except that, the department may enter into agreements with other state agencies or a private vendor, as necessary, to ensure the effective operations of the program if such agreements are funded solely from gifts, grants, and donations. Any agency or private vendor entering into an agreement with the department for the pilot project shall comply with the confidentiality provisions regarding the prescription information under section 195.456.

6. Under section 23.253 of the Missouri sunset act:

(1) The provisions of the new program authorized under this section shall automatically sunset three years after the effective date of this section unless reauthorized by an act of the general assembly; and

(2) If such program is reauthorized, the program authorized under this section shall automatically sunset twelve years after the effective date of the reauthorization of this section; and

(3) This section shall terminate on September first of the calendar year immediately following the calendar year in which the program authorized under this section is sunset.

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as defined in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the MO HealthNet division not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. 301, et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The MO HealthNet division when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection for those days, which shall not exceed twelve per any period of six consecutive months, during which the participant is on a temporary leave of absence from the hospital or nursing home, provided that no such participant shall be allowed a temporary leave of absence unless it is specifically provided for in his plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a participant is away from the hospital or nursing home overnight because he is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere;

(7) Drugs and medicines when prescribed by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse; except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse may be made on behalf of any person who qualifies for prescription drug coverage under the provisions of P.L. 108-173;

(8) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments;

(9) Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 and federal regulations promulgated thereunder;

(10) Home health care services;

(11) Family planning as defined by federal rules and regulations; provided, however, that such family planning services shall not include abortions unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in his professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(12) Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. 1396d, et seq.);

(13) Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(14) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his physician on an outpatient rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the participant's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198 shall be authorized on a tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if her or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are approved or a determination of noncompliance is made;

(15) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. 301, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097. The department of mental health shall establish by administrative rule the definition

and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, mental health professional and alcohol and drug abuse professional shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, MO HealthNet division, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(16) Such additional services as defined by the MO HealthNet division to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. 301, et seq.) subject to appropriation by the general assembly;

(17) The services of an advanced practice registered nurse with a collaborative practice agreement to the extent that such services are provided in accordance with chapters 334 and 335, and regulations promulgated thereunder;

(18) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection to reserve a bed for the participant in the nursing home during the time that

the participant is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO HealthNet certified licensed beds, according to the most recent quarterly census provided to the department of health and senior services which was taken prior to when the participant is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a participant under this subdivision during any period of six consecutive months such participant shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant or the participant's responsible party that the participant intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the participant or the participant's responsible party prior to release of the reserved bed;

(19) Prescribed medically necessary durable medical equipment. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(20) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient,

in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(21) Prescribed medically necessary dental services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(22) Prescribed medically necessary optometric services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(23) Blood clotting products-related services. For persons diagnosed with a bleeding disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section 338.400, such services include:

(a) Home delivery of blood clotting products and ancillary infusion equipment and supplies, including the emergency deliveries of the product when medically necessary;

(b) Medically necessary ancillary infusion equipment and supplies required to administer the blood clotting products; and

(c) Assessments conducted in the participant's home by a pharmacist, nurse, or local home health care agency trained in bleeding disorders when deemed necessary by the participant's treating physician;

(24) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental reimbursement rates. Such plan shall be subject to appropriation and the division shall include in its annual budget request to the governor the necessary funding needed to complete the four-year plan developed under this subdivision.

2. Additional benefit payments for medical assistance shall be made on behalf of **[**those eligible needy children, pregnant women and blind persons**]** **all MO HealthNet recipients** with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the division of medical services, unless otherwise hereinafter provided, for the following:

(1) Dental services;

(2) Services of podiatrists as defined in section 330.010;

(3) Optometric services as defined in section 336.010;

(4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;

(5) Hospice care. As used in this **[**subsection**]** **subdivision**, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(6) **Prescribed medically necessary rehabilitative services, including physical therapy, occupational therapy, and speech therapy. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need; and**

(7) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this subdivision shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July

1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (14) and (15) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and not in lieu of payments made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the Missouri MO HealthNet state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

4. The MO HealthNet division shall have the right to collect medication samples from participants in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for MO HealthNet benefits at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for MO HealthNet benefits under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the MO HealthNet program shall not increase payments in excess of the increase that would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. 1396a (a)(13)(C).

10. The MO HealthNet division, may enroll qualified residential care facilities and assisted living facilities, as defined in chapter 198, as MO HealthNet personal care providers.

11. Any income earned by individuals eligible for certified extended employment at a sheltered workshop under chapter 178 shall not be considered as income for purposes of determining eligibility under this section.

12. The department shall immediately seek any necessary waivers from the federal Department of Health and Human Services to implement the provisions of this chapter for all MO HealthNet recipients in order to:

(1) Promote healthy behavior and reasonable requirements that recipients take ownership of their health care by seeking early preventative care in appropriate settings, including no co-payments for preventive care services;

(2) Promote the adoption of healthier personal habits, including limiting tobacco use or behaviors that lead to obesity; and

(3) Allow health plans to offer a health savings account option.

208.153. 1. Pursuant to and not inconsistent with the provisions of sections 208.151 and 208.152, the MO HealthNet division shall by rule and regulation define the reasonable costs, manner, extent, quantity, quality, charges and fees of MO HealthNet benefits herein provided. The benefits available under these sections shall not replace those provided under other federal

or state law or under other contractual or legal entitlements of the persons receiving them, and all persons shall be required to apply for and utilize all benefits available to them and to pursue all causes of action to which they are entitled. Any person entitled to MO HealthNet benefits may obtain it from any provider of services with which an agreement is in effect under this section and which undertakes to provide the services, as authorized by the MO HealthNet division. At the discretion of the director of the MO HealthNet division and with the approval of the governor, the MO HealthNet division is authorized to provide medical benefits for participants receiving public assistance by expending funds for the payment of federal medical insurance premiums, coinsurance and deductibles pursuant to the provisions of Title XVIII B and XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), as amended.

2. MO HealthNet shall include benefit payments on behalf of qualified Medicare beneficiaries as defined in 42 U.S.C. Section 1396d(p). The family support division shall by rule and regulation establish which qualified Medicare beneficiaries are eligible. The MO HealthNet division shall define the premiums, deductible and coinsurance provided for in 42 U.S.C. Section 1396d(p) to be provided on behalf of the qualified Medicare beneficiaries.

3. MO HealthNet shall include benefit payments for Medicare Part A cost sharing as defined in clause (p)(3)(A)(i) of 42 U.S.C. **Section** 1396d on behalf of qualified disabled and working individuals as defined in subsection (s) of Section 42 U.S.C. **Section** 1396d as required by subsection (d) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989). The MO HealthNet division may impose a premium for such benefit payments as authorized by paragraph (d)(3) of Section 6408 of P.L. 101-239.

4. MO HealthNet shall include benefit payments for Medicare Part B cost sharing described in 42 U.S.C. Section 1396(d)(p)(3)(A)(ii) for individuals described in subsection 2 of this section, but for the fact that their income exceeds the income level established by the state under 42 U.S.C. Section 1396(d)(p)(2) but is less than one hundred and ten percent beginning January 1, 1993, and less than one hundred and twenty percent beginning January 1, 1995, of the official poverty line for a family of the size involved.

5. For an individual eligible for MO HealthNet under Title XIX of the Social Security Act, MO HealthNet shall include payment of enrollee premiums in a group health plan and all deductibles, coinsurance and other cost-sharing for items and services otherwise covered under the state Title XIX plan under Section 1906 of the federal Social Security Act and regulations established under the authority of Section 1906, as may be amended. Enrollment in a group health plan must be cost effective, as established by the Secretary of Health and Human Services, before enrollment in the group health plan is required. If all members of a family are not eligible for MO HealthNet and enrollment of the Title XIX eligible members in a group health plan is

not possible unless all family members are enrolled, all premiums for noneligible members shall be treated as payment for MO HealthNet of eligible family members. Payment for noneligible family members must be cost effective, taking into account payment of all such premiums. Non-Title XIX eligible family members shall pay all deductible, coinsurance and other cost-sharing obligations. Each individual as a condition of eligibility for MO HealthNet benefits shall apply for enrollment in the group health plan.

6. Any Social Security cost-of-living increase at the beginning of any year shall be disregarded until the federal poverty level for such year is implemented.

7. **(1)** If a MO HealthNet participant has paid the requested spenddown in cash for any month and subsequently pays an out-of-pocket valid medical expense for such month, such expense shall be allowed as a deduction to future required spenddown for up to three months from the date of such expense.

(2) Beginning January 1, 2015, and notwithstanding any other provision of law to the contrary, all persons eligible for MO HealthNet benefits shall have a continuous twelve months of eligibility, including all spenddown recipients, after a determination of eligibility is made.

(3) Potential exchange-eligible participants who may be eligible for services due to spenddown shall be notified by the department that such participants may qualify for more cost-effective private insurance and premium tax credits under Section 36B of the Internal Revenue Code of 1986, as amended, available through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state based, or operated on a partnership basis and the benefits that would be potentially covered under such insurance.

208.166. 1. As used in this section, the following terms mean:

(1) "Department", the Missouri department of social services;

(2) "Prepaid capitated", a mode of payment by which the department periodically reimburse a contracted health provider plan or primary care physician sponsor for delivering health care services for the duration of a contract to a maximum specified number of members based on a fixed rate per member, notwithstanding:

(a) The actual number of members who receive care from the provider; or

(b) The amount of health care services provided to any members;

(3) "Primary care case-management", a mode of payment by which the department reimburses a contracted primary care physician sponsor on a fee-for-service schedule plus a monthly fee to manage each recipient's case;

(4) "Primary care physician sponsor", a physician licensed pursuant to chapter 334 who is a family practitioner, general practitioner, pediatrician, general internist or an obstetrician or gynecologist;

(5) "Specialty physician services arrangement", an arrangement where the department may restrict recipients of specialty services to designated providers of such services, even in the absence of a primary care case-management system.

2. The department or its designated division shall maximize the use of prepaid health plans, where appropriate, and other alternative service delivery and reimbursement methodologies, including, but not limited to, individual primary care physician sponsors or specialty physician services arrangements, designed to facilitate the cost-effective purchase of comprehensive health care.

3. In order to provide comprehensive health care, the department or its designated division shall have authority to:

(1) Purchase medical services for recipients of public assistance from prepaid health plans, health maintenance organizations, health insuring organizations, preferred provider organizations, individual practice associations, local health units, community health centers, or primary care physician sponsors;

(2) Reimburse those health care plans or primary care physicians' sponsors who enter into direct contract with the department on a prepaid capitated or primary care case-management basis on the following conditions:

(a) That the department or its designated division shall ensure, whenever possible and consistent with quality of care and cost factors, that publicly supported neighborhood and community-supported health clinics shall be utilized as providers;

(b) That the department or its designated division shall ensure reasonable access to medical services in geographic areas where managed or coordinated care programs are initiated; and

(c) That the department shall ensure full freedom of choice for prescription drugs at any Medicaid participating pharmacy;

(3) Limit providers of medical assistance benefits to those who demonstrate efficient and economic service delivery for the level of service they deliver, and provided that such limitation shall not limit recipients from reasonable access to such levels of service;

(4) Provide recipients of public assistance with alternative services as provided for in state law, subject to appropriation by the general assembly;

(5) Designate providers of medical assistance benefits to assure specifically defined medical assistance benefits at a reduced cost to the state, to assure reasonable access to all levels of health services and to assure maximization of federal financial participation in the delivery

of health related services to Missouri citizens; provided, all qualified providers that deliver such specifically defined services shall be afforded an opportunity to compete to meet reasonable state criteria and to be so designated;

(6) Upon mutual agreement with any entity of local government, to elect to use local government funds as the matching share for Title XIX payments, as allowed by federal law or regulation;

(7) To elect not to offset local government contributions from the allowable costs under the Title XIX program, unless prohibited by federal law and regulation.

4. Nothing in this section shall be construed to authorize the department or its designated division to limit the recipient's freedom of selection among health care plans or primary care physician sponsors, as authorized in this section, who have entered into contract with the department or its designated division to provide a comprehensive range of health care services on a prepaid capitated or primary care case-management basis, except in those instances of overutilization of Medicaid services by the recipient.

5. Beginning January 1, 2015, all health insurers offering health insurance plans in the MO HealthNet program shall also offer such plans for purchase in the private market and in any health care exchange operating in this state, whether federally facilitated, state based, or operated on a partnership basis. Any health insurer who violates the provisions of this section shall be subject to sanction or cancellation of its MO HealthNet contract with the MO HealthNet division.

208.427. 1. The department of social services shall ensure that managed care organizations establish and maintain adequate provider networks to serve MO HealthNet populations as designated by the department, and shall establish and maintain network adequacy standards in its contracts with managed care plans described in section 208.428. Managed care plans shall establish and maintain health plan provider networks in geographically accessible locations in accordance with travel distances specified by the department in its managed care contracts and required by the department of insurance, financial institutions and professional registration.

2. Managed care plan networks shall, at a minimum, consist of hospitals, physicians, advance practice registered nurses, behavioral health providers, substance abuse providers, dentists, emergency and nonemergency transportation services, federally qualified health centers, rural health centers, women's health specialists, local public health agencies, family planning and sexually transmitted disease (STD) providers, and all other provider types necessary to ensure sufficient capacity to make available all services in accordance with the service accessibility standards specified by the department.

3. Managed care organizations shall notify the department on a timely basis of all changes to its provider networks. The department shall set forth the requirements for such notification in its contracts with managed care plans.

4. Managed care organizations shall post all of their provider networks on the organization's website and shall regularly update their postings of such networks on at least a monthly basis. A provider who is not accepting new patients under a given managed care plan shall be listed as a provider not accepting new patients. The department shall set forth the requirements for such posting in its contracts with managed care plans.

5. To ensure that managed care plans comply with network adequacy standards, the MO HealthNet division shall contract with an independent organization which does not contract or consult with managed care plans or insurers to conduct secret surveys of MO HealthNet managed care plans for compliance with provider network adequacy standards on a regular basis. The department shall develop the policies and procedures for conducting such secret surveys. Secret surveys shall be paid for by each of the managed care plans from their administrative budget, but shall be performed by contracted agents of the department.

6. Inadequacy of provider networks, as determined by the department from the secret surveys or otherwise, and the publication of false and misleading information about the composition of health plan provider networks shall be the basis for sanctions against managed care plans, in a manner to be determined by the department. Material changes in network composition that negatively affect member access to services may be grounds for contract cancellation or state-determined sanctions.

7. Managed care plans shall also ensure sufficient access to out-of-network providers when necessary to meet the health needs of enrollees in accordance with standards developed by the department and included in its managed care contracts.

208.428. 1. Managed care plans authorized by the department:

(1) Shall comply with federal Medicaid requirements as authorized by federal law or through a federal waiver;

(2) May include accountable care organizations, administrative service organizations, or managed care organizations paid on a capitated basis;

(3) Shall, to the greatest extent possible, promote the opportunity for children and their parents to be covered under the same plan;

(4) Shall encourage access to care through provider rates that include pay-for-performance and are comparable to commercial rates;

(5) Shall provide incentives, including shared risk and savings, to managed care plans and providers in order to encourage cost-effective delivery of care;

(6) May provide multiple plan options and reward participants for choosing a low-cost plan; and

(7) Shall include the services of health providers as defined in 42 U.S.C. Section 1396d(l)(1) and (2) and meet the payment requirements for such health providers as provided in 42 U.S.C. Sections 1396a(a)(15) and 1396a(bb).

2. The department may designate that certain health care services be excluded from such managed care plans if it is determined cost effective by the department.

3. The department may accept regional plan proposals as an additional option for beneficiaries if such plans are cost effective.

4. (1) The department shall establish a competitive bidding process for contracting with managed care plans.

(2) A managed care bidder shall include a process in its bid by which MO HealthNet recipients who enroll in its plan shall be automatically enrolled in the insurer's corresponding plan offered within the health care exchange if the recipient's income increases, resulting in the recipient's ineligibility for MO HealthNet benefits.

(3) The department shall select a minimum of three winning bids and may select up to a maximum number of bids equal to the quotient derived from dividing the total number of participants anticipated by the department in a region by one hundred thousand.

(4) The department shall accept the most cost-effective conforming bid. For determining other accepted bids, the department shall consider the following factors:

(a) The cost to Missouri taxpayers;

(b) The extent of the network of health care providers offering services within the bidder's plan;

(c) Additional services offered to recipients under the bidder's plan;

(d) The bidder's history of providing managed care plans for similar populations in Missouri or other states;

(e) Any other criteria the department deems relevant to ensuring MO HealthNet benefits are provided to recipients in such manner as to save taxpayer money and improve health outcomes of recipients.

5. Any managed care organization that enters into a contract with the state to provide managed care plans shall be required to fulfill the terms of the contract and provide such plans for at least twelve months, or longer if the contract so provides. The state shall not increase the reimbursement rate provided to the managed care organization

during the contract period above the rate included in the contract. If the managed care organization breaches the contract, the state shall be entitled to bring an action against the managed care organization for any remedy allowed by law or equity and shall also recover any and all damages provided by law, including liquidated damages in an amount determined by the department during the bidding process. Nothing in this subsection shall be construed to preclude the department or the state of Missouri from terminating the contract as specified in the terms of the contract, including for breach of contract, lack of appropriated funds, or exercising any remedies for breach as may be provided in the contract.

6. (1) Participants enrolling in managed care plans under this section shall have the ability to choose their plan. In the enrollment process, participants shall be provided a list of all plans available ranked by the relative actuarial value of each plan. Each participant shall be informed in the enrollment process that he or she will be eligible to receive a portion of the amount saved by Missouri taxpayers if he or she chooses a lower cost plan offered in his or her region. The portion received by a participant shall be determined by the department according to the department's best judgment as to the portion which will bring the maximum savings to Missouri taxpayers.

(2) If a participant fails or refuses to choose a plan as set forth in subdivision (1) of this subsection, the department shall determine rules for automatic assignment, which shall include incentives for low-cost bids and improved health outcomes as determined by the department.

7. This section shall not be construed to require the department to terminate any existing managed care contract or to extend any managed care contract.

8. All MO HealthNet plans under this section shall provide coverage for the following services unless they are specifically excluded under subsection 2 of this section and instead are provided by an administrative services organization:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

(5) Mental health and substance abuse treatment, including behavioral health treatment;

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness care, and chronic disease management;

(10) Pediatric services, including oral and vision care; and

(11) Any other services required by federal law.

208.429. 1. The department shall, in collaboration with plans and providers, establish uniform utilization review protocols to be used by all authorized managed care plans.

2. MO HealthNet managed care organizations shall provide information to the department on at least a quarterly basis and the MO HealthNet division shall publicly report such information within thirty days of receipt, including posting on its website at least the following information:

(1) Service utilization data, including how many of each service was requested, delivered, and denied, subtotaled by age, race, gender, geographic location, and type of service. Denials shall include partial denials whereby a requested service is approved but in a different amount, duration, scope, frequency, or intensity than requested;

(2) Results of network adequacy reviews, including geo-mapping and waiting times, stratified by factors including provider type, geographic location, and urban/rural, and any finding of adequacy/inadequacy and remedial actions taken. Such information shall also include any findings with respect to the accuracy of networks as published by managed care organizations, including providers found to be not participating and not accepting new patients;

(3) Data regarding complaints, grievances and appeals, including numbers of complaints, grievances and appeals filed, stratified by factors including age, race, gender, geographic location, type of service, and detailing the time frame data for hearings and decisions made and the dispositions of resolutions of complaints, grievances, and appeals;

(4) Monthly data regarding denials and partial denials by managed care organizations or their subcontractors for each category of services provided to MO HealthNet enrollees;

(5) Plan disenrollment data by cause and by month with the particular managed care plan prior to disenrollment;

(6) Provider change data indicating how many enrollees changed their primary care provider, by cause, months of enrollment, and form of enrollment, such as passive enrollment, or enrollee election;

(7) Quality measurement data, including at a minimum all Healthcare Effectiveness Data and Information Set (HEDIS) measures, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening data, and any other appropriate measures as determined by the department;

(8) Consumer satisfaction surveying data;

(9) Medical loss ratios, including the medical loss ratios of any capitated subcontractors based on the percentage of the subcapitated payments made by the managed care plan to the subcontractor which is expended on health care for the plan's enrollees;

(10) Enrollee telephone access reports, including the number of unduplicated calls by enrollees, average wait times before contractor response, number of unduplicated enrollees requiring language interpretation services, and enrollee services telephone abandonment rate;

(11) Any data related to preventable hospitalizations, hospital acquired infections, never events, and emergency room admission. For purposes of this subdivision, "never events" mean adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability;

(12) Provider compensation rates for all categories of providers; and

(13) Any additional reported data obtained from the managed care plans which relates to the performance of the plans in terms of cost, quality, access to providers or services, or other measures.

208.430. Each capitated managed care plan and each captitated subcontracting plan shall maintain a medical loss ratio of at least eighty-five percent for MO HealthNet operations. "Medical loss ratio" shall have the same meaning as such term is defined in Section 1001 of the Patient Protection and Affordable Care Act and 45 CFR Part 158. If a managed care plan's medical loss ratio falls below eighty-five percent in a given month, the managed care plan shall refund to the state the portion of the capitation rates paid to the managed care plan in the amount equal to the difference between the plan's medical loss ratio and eighty-five percent of the capitated payments to the managed care plan.

208.965. 1. The MO HealthNet division shall develop and implement the "Health Care Homes Program" as a provider-directed care coordination program. The health care homes program shall provide payment to primary care clinics for care coordination for individuals who are deemed medically frail, as defined in section 208.991, and for any other MO HealthNet recipients as deemed cost effective by the department. Clinics shall meet certain criteria, including but not limited to the following:

(1) The capacity to develop care plans;

(2) A dedicated care coordinator;

(3) An adequate number of clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement; and

(4) The capability to maintain and use a disease registry.

2. For purposes of this section, "primary care clinic" means a medical clinic designated as the patient's first point of contact for medical care that is:

(1) Available twenty-four hours a day, seven days a week;

(2) Provides or arranges the patient's comprehensive health care needs; and

(3) Provides overall integration, coordination, and continuity over time and referrals for specialty care.

A primary care clinic shall include a community health care center.

3. The health care home for recipients of MO HealthNet services who meet the definition of medically frail under paragraph (f) of subdivision (6) of subsection 1 of section 208.991 shall be the primary provider of home- and community-based services received by the recipient if such provider has a qualified licensed designee to serve as the recipient's care coordinator and the provider can demonstrate the ability to meet the requirements in subsections 1 and 2 of this section. The qualifications for such designees shall be defined by the department by rule.

4. Providers of behavioral, social, and psychophysiological services for the prevention, treatment, or management of physical health problems and screening and brief intervention shall be reimbursed for utilizing the behavior assessment and intervention, and screening and brief intervention reimbursement codes 96150 to 96155 and 99408 to 99409, or their successor codes under the Current Procedural Terminology (CPT) coding system. Location of service may be limited to National Committee for Quality Assurance (NCQA) Level 3 Patient-Centered Medical Homes and health homes accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

5. Nothing in this section shall be construed to limit the department's ability to create health care homes for participants in a managed care plan, children, and other appropriate groups. To the extent not prohibited by federal law or regulation, and for persons who are dual-eligible for both Medicare and MO HealthNet benefits, such persons may participate in either a Medicare health care homes program or a MO HealthNet health care homes program without any loss of benefits or services as a dual-eligible recipient.

6. The department may designate that the health care homes program be administered through an organization with a primary care presence, experience with Medicaid population health management, and an established health homes outcomes monitoring and improvement system.

7. The provisions of this section shall not be implemented in such a manner which conflicts with the federal requirements for health care home participation by MO HealthNet participants.

8. The department shall promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

208.967. Subject to appropriations, the department shall develop incentive programs to encourage the construction and operation of urgent care clinics which operate outside normal business hours and are in or adjoining emergency room facilities which receive a high proportion of patients who are participating in MO HealthNet, to the extent that the incentives are eligible for federal matching funds.

208.991. 1. For purposes of **[**this section and section 208.990**]** **sections 208.990 to 208.998**, the following terms mean:

(1) "Child" or "children", a person or persons who are under nineteen years of age;

(2) "CHIP-eligible children", children who meet the eligibility standards for Missouri's children's health insurance program as provided in sections 208.631 to 208.658, including paying the premiums required under sections 208.631 to 208.658;

(3) "Department", the Missouri department of social services, or a division or unit within the department as designated by the department's director;

(4) "MAGI", the individual's modified adjusted gross income as defined in Section 36B(d)(2) of the Internal Revenue Code of 1986, as amended, and:

(a) Any foreign earned income or housing costs;

(b) Tax-exempt interest received or accrued by the individual; and

(c) Tax-exempt Social Security income;

(5) "MAGI equivalent net income standard", an income eligibility threshold based on modified adjusted gross income that is not less than the income eligibility levels that were in effect prior to the enactment of Public Law 111-148 and Public Law 111-152**;**

(6) "Medically frail", individuals with:

(a) Serious emotional disturbances;

(b) Disabling mental disorders;

(c) Substance use disorders or chronic medical conditions who are at high risk for significant medical and social costs;

(d) Serious and complex medical conditions, including children who are deemed medically complex;

(e) Physical or mental disabilities that significantly impair the person's ability to perform one or more activities of daily living; or

(f) An adjudicated level of care of twenty-one points or greater as determined by the screening process under 42 CFR 483.100 to 483.138, or deemed eligible for skilled nursing facility placement, but who are not currently residing in a nursing facility.

2. (1) **[**Effective January 1, 2014, notwithstanding any other provision of law to the contrary, the following individuals shall be eligible for MO HealthNet coverage as provided in this section:

(a) Individuals covered by MO HealthNet for families as provided in section 208.145;

(b) Individuals covered by transitional MO HealthNet as provided in 42 U.S.C. Section 1396r-6;

(c) Individuals covered by extended MO HealthNet for families on child support closings as provided in 42 U.S.C. Section 1396r-6;

(d) Pregnant women as provided in subdivisions (10), (11), and (12) of subsection 1 of section 208.151;

(e) Children under one year of age as provided in subdivision (12) of subsection 1 of section 208.151;

(f) Children under six years of age as provided in subdivision (13) of subsection 1 of section 208.151;

(g) Children under nineteen years of age as provided in subdivision (14) of subsection 1 of section 208.151;

(h) CHIP-eligible children; and

(i) Uninsured women as provided in section 208.659.

(2) Effective January 1, 2014, the department shall determine eligibility for individuals eligible for MO HealthNet under subdivision (1) of this subsection based on the following income eligibility standards, unless and until they are:

(a) For individuals listed in paragraphs (a), (b), and (c) of subdivision (1) of this subsection, the department shall apply the July 16, 1996, Aid to Families with Dependent Children (AFDC) income standard as converted to the MAGI equivalent net income standard;

(b) For individuals listed in paragraphs (f) and (g) of subdivision (1) of this subsection, the department shall apply one hundred thirty-three percent of the federal poverty level converted to the MAGI equivalent net income standard;

(c) For individuals listed in paragraph (h) of subdivision (1) of this subsection, the department shall convert the income eligibility standard set forth in section 208.633 to the MAGI equivalent net income standard;

(d) For individuals listed in paragraphs (d), (e), and (i) of subdivision (1) of this subsection, the department shall apply one hundred eighty-five percent of the federal poverty level converted to the MAGI equivalent net income standard.

(3) Individuals eligible for MO HealthNet under subdivision (1) of this subsection shall receive all applicable benefits under section 208.152.

3.**] Beginning January 1, 2015, individuals age nineteen to sixty-four, who are not otherwise eligible for MO HealthNet services under this chapter, who qualify for MO HealthNet services under 42 U.S.C. Section 1396a(a)(10)(A)(i)(VIII) and as set forth in 42 CFR 435.119, and who have income at or below one hundred thirty-three percent of the federal poverty level plus five percent of the applicable family size as determined under 42 U.S.C. Section 1396a(e)(14) and as set forth in 42 CFR 435.603, shall be eligible for all benefits under MO HealthNet.**

(2) The provisions of sections 208.990 to 208.998 shall be null and void unless and until:

(a) The health insurance premium tax credits under Section 36B of the Internal Revenue Code of 1986, as amended, are available to persons through the purchase of a health insurance plan in a heath care exchange, whether federally facilitated, state based, or operated on a partnership basis;

(b) The federal Department of Health and Human Services grants the required waivers, state-plan amendments, and enhanced federal funding rate for persons newly eligible whereby the federal government agrees to pay the percentages specified in Section 2001 of P.L. 111-148, as that section existed on March 23, 2010.

(3) If the federal funds at the disposal of the state shall at any time become less than ninety percent of the funds necessary or are not appropriated to pay the percentages specified in Section 2001 of P.L. 111-148, as that section existed on March 23, 2010, the provisions of sections 208.990 to 208.998 shall be null and void. If the director is notified that federal funding will fall below ninety percent of the funds necessary, participants shall be notified as soon as practicable that the benefits they receive will terminate on the date that federal funding falls below ninety percent.

(4) As MO HealthNet or other expenditures are reduced or savings achieved under this act, the portion of the state share of such expenditures funded by provider taxes described in 42 CFR 433.56 shall be credited or otherwise accrue to the depository account in which the proceeds of such provider tax are deposited.

3. Beginning January 1, 2015, for persons who have an income between one hundred percent and one hundred thirty-eight percent of the federal poverty level for the applicable family size for the applicable year under the MAGI equivalent net income standard, who meet all other requirements under subsection 2 of this section, and who have not been determined to be medically frail by the department, the department may offer to or obtain for such persons health care coverage through a health care exchange operating in this state, whether federally facilitated, state based, or operated on a partnership basis, or through an employer if such coverage is determined by the department to save taxpayer money and improve health outcomes or benefit a participant's care or continuity of care. The department shall ensure the participants receive the minium services required to ensure federal reimbursement at the percentages specified in Section 2001 of P.L. 111-148. The department shall require cost sharing to the maximum extent allowed by law.

4. (1) The department shall provide premium subsidies and other cost supports for individuals eligible for MO HealthNet under this section to enroll in employer-sponsored health plans or other private health plans based on cost-effective principles determined by the department.

(2) The department may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

5. Beginning January 1, 2015, all persons who meet the definition of medically frail shall receive all benefits they are eligible to receive under sections 208.152, 208.900, 208.903, 208.909, 208.930, and 208.965.

6. The department, in conjunction with the department of mental health and the department of health and senior services, shall establish a screening process for determining whether an individual is medically frail. The department shall enroll all eligible individuals who meet the definition of medically frail and whose care management would benefit from being assigned a health home in the health home program under section 208.997 or other care coordination as established by the department. Any eligible individual may opt out of the health home program.

7. The department or appropriate divisions of the department shall promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as the term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2013, shall be invalid and void.

[4.**]** **8.** The department shall submit such state plan amendments and waivers to the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services as the department determines are necessary to implement the provisions of this section. **The department shall request of the federal government an enhanced federal funding rate for persons newly eligible under this section whereby the federal government agrees to pay the percentages specified in Section 2001 of P.L. 111-148, as that section existed on March 23, 2010. The provisions of this section shall not be implemented unless such waivers and enhanced federal funding rates are granted by the federal government.**

9. If at any time the director receives notice that the federal funds at the disposal of the state for payments of money benefits to or on behalf of any persons under this section shall at any time become less than ninety percent of the funds necessary or are not appropriated to pay the percentages specified in Section 2001 of P.L. 111-148, as that section existed on March 23, 2010, this section shall no longer be effective for the individuals whose benefits are no longer matchable at the specified percentages. The date benefits cease shall be stated in a notice sent to the affected individuals.

208.998. 1. All participants with chronic conditions, as specified by the department, shall be included in an incentive program for MO HealthNet recipients who obtain specified primary care and preventive services, and who participate or refrain from participation in specified activities to improve the overall health of the recipient. Such incentives may include, but are not limited to, cash payments for participants who successfully complete the requirements of any program created under this subsection.

2. The department shall establish by rule the specific primary care and preventive services, activities to be included in the incentive program, the amount of any incentives or cash payments to participants, and the circumstances under which any such incentives or cash payments may be reduced or eliminated if the participant utilizes visits to the emergency department for nonemergency purposes.

3. No cash payments, incentives, or credits paid to or on behalf of a MO HealthNet participant under a program established by the department under this section shall be deemed to be income to the participant in any means-tested benefit program unless otherwise specifically required by law or rule of the department.

4. The department shall inform participants that he or she may lose eligibility for any incentive payment under this section if the participant utilizes visits to the emergency department for nonemergent purposes. Such information shall be included on every electronic and paper correspondence between the managed care plan and the participant.

5. The department shall seek all necessary waivers and state plan amendments from the federal Department of Health and Human Services necessary to implement the provisions of this section. The provisions of this section shall not be implemented unless such waivers and state plan amendments are approved. If this section is approved in part by the federal government, the department is authorized to proceed on those sections for which approval has been granted; except that, any increase in eligibility shall be contingent upon the receipt of all necessary waivers and state plan amendments.

6. The department shall promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as the term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2014, shall be invalid and void.

Section 1. 1. The department of social services shall submit a state plan amendment to the Centers for Medicare and Medicaid (CMS) for approval to establish a Section 1915(i) Home and Community-Based Services benefit to encourage the provision of home and community-based services and assisted living services prior to a recipient meeting the requirements for skilled nursing care benefits. Such HCBS state plan benefits shall combine acute-care medical services and long-term care services to ensure that recipients receive services in the least restrictive environment based on the level of care and services needed for each recipient. The state plan amendments may include:

(1) Targeting of the HCBS benefit to one or more specific populations;

(2) Establishing a separate additional needs-based criteria for individual HCBS;

(3) Establishing a new MO HealthNet eligibility group for persons who receive state plan HCBS;

(4) Defining the HCBS included in the benefit, such as including state-defined and other CMS-approved services applicable to the population; and

(5) An option to allow any or all HCBS to be self-directed.

2. Subject to federal approval, the department of social services shall eliminate the age requirement for home and community-based waiver services for persons who meet the permanent and total disabilities requirements.

Section 2. Any voluntary premium assistance program developed and implemented under the MO HealthNet program shall provide the department with the maximum flexibility of providing such assistance through marketplace health insurance plans, employer-sponsored health insurance, or other appropriate health insurance plans which will save taxpayer money and improve health outcomes or benefit a participant's care or continuity of care based on the participant's individual circumstances and needs.

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